



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
DEPARTMENT OF STATE  
DIVISION OF PROFESSIONAL REGULATION  
**BOARD OF PODIATRY**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: DPR.DELAWARE.GOV

**APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE  
INSTRUCTION SHEET**

**Selecting Type of Application**

The application asks you to select the type of application you are filing. The two types of application are *Direct Application* and *Reciprocity*. Which you choose depends on whether you are *currently* licensed in another jurisdiction (state, U.S. territory or District of Columbia) and, if so, whether any of the jurisdictions has licensure requirements substantially similar to those of Delaware.

Select **Direct Application** if *either* of these situations applies to you:

- You recently completed your residency year and are **not** licensed in another jurisdiction, **or**
- You hold a current license in another jurisdiction(s) but you have **not** practiced podiatric medicine *at least* five years **and none** of the jurisdictions where you are currently licensed has licensure requirements that are substantially similar to those of Delaware.

Select **Reciprocity** if you are *currently* licensed in another jurisdiction **and either** of these situations applies to you:

- A jurisdiction where you are currently licensed has licensure requirements that are substantially similar to those of Delaware, **or**
- You have practiced podiatric medicine *at least* five years in a jurisdiction where you are currently licensed even though the jurisdiction does not have licensure requirements substantially similar to Delaware's.

To compare the licensure requirements of a jurisdiction where you are currently licensed to those of Delaware, see Section 4.2 of the Board's [Rules and Regulations](#).

If you select Reciprocity, the Board will compare the licensure requirements of each jurisdiction where you hold a current license to those of Delaware. If the Board determines that **none** of the jurisdictions has substantially similar requirements **and** you have **not** practiced podiatric medicine for five years, you would be required to meet the requirements for licensure by Direct Application because you cannot be licensed by Reciprocity.

**Requirements for All Applicants**

These requirements apply regardless of whether you apply by Direct Application or Reciprocity.

- ☐ Submit a completed, signed, notarized [Application for Licensure to Practice Podiatric Medicine](#).
- ☐ Enclose [processing fee](#) by check or money order made payable to "State of Delaware."
- ☐ Arrange for the Board office to receive an official transcript sent *directly* from your school of podiatric medicine to Board office.
- ☐ Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov). The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the **original report** to the Board office.
- ☐ Arrange for the Board office to receive verification of licensure from *each* jurisdiction in which you hold, or have ever held, a license to practice podiatric medicine, sent *directly* from the jurisdiction to the Board office.
  - If applying by Reciprocity, you must hold a *current* license in at least one of these jurisdictions.

- ☐ If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
- *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

#### **Additional Requirements for *Direct Applicants***

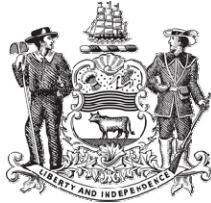
The following requirements apply only if you select Direct Application:

- ☐ Submit a certificate or equivalent proof that you have completed your residency.
- ☐ Arrange for the Board office to receive score reports sent *directly* from the following exam services:
- For scores on the American Podiatric Medical Licensing Examinations (APMLE) Parts I and II, see [www.nbpme.org](http://www.nbpme.org).
  - For scores on the APMLE Part III, see [www.fpmb.org](http://www.fpmb.org).

#### **Additional Requirements for *Reciprocity Applicants***

The following requirements apply only if you select Reciprocity. To be licensed by Reciprocity without five years of practice, at least one jurisdiction where you are currently licensed must have licensure requirements substantially similar to Delaware's. However, if you have practiced podiatric medicine for at least five years, it is not necessary for a jurisdiction where you are currently licensed to have licensure requirements substantially similar to Delaware's.

- ☐ Provide copies of the current Podiatry laws and rules/regulations from each jurisdiction where you are currently licensed.
- ☐ If you have practiced podiatric medicine for at least five years, submit proof of five years of practice.
- For periods of employment, arrange for your employers to submit [Verification of Employment](#) forms directly to the Board office.
  - For periods of self-employment, submit copies of tax forms or business licenses.



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**APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE**

**TYPE OF APPLICATION**

1. Select the type of application you are filing (check one). The Instruction Sheet explains these types.

- ☐ Direct Licensure  
☐ Reciprocity – I hold a *current* license in these jurisdictions: \_\_\_\_\_

**If you are applying by *Reciprocity*, submit current copies of Podiatry statutes and rules and regulations from each jurisdiction listed above.**

**IDENTIFYING AND CONTACT INFORMATION**

2. Name: \_\_\_\_\_  
Last/Family First Middle

3. Other Names Used: \_\_\_\_\_

4. Date of Birth (month/day/year): \_\_\_\_\_ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: \_\_\_\_\_  
If no, you must file a [Request for Exemption from Social Security Number Requirement](#).

6. Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip Code

7. Day Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**EDUCATION AND EXAMINATIONS**

8. Enter the following information about the institution where you received your DPM:

Name: \_\_\_\_\_ Date of Degree: \_\_\_\_\_

Address: \_\_\_\_\_

**Arrange for your school to send an official transcript *directly* to the Board office.**

9. Enter the following information about your residency:

Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_

Director: \_\_\_\_\_ Attendance Dates: \_\_\_\_\_  
From To

**If applying by *Direct Application*, submit a certificate or other proof of completing your residency.**

10. Enter the requested information about your exams:

If applying by *Direct Application*, arrange for the Board office to receive score reports sent *directly* from the exam service.

EXAMINATION	SCORE	EXAM DATE
APMLE Part I		
APMLE Part II		
APMLE Part III		

## LICENSURE AND PRACTICE HISTORY

11. Have you ever been granted a podiatric license by any jurisdiction (state, U.S. territory or D.C.)? Yes ☐ No ☐ If yes, complete the following for all licenses. Use a separate sheet if necessary.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	STATUS (current or expired)

Arrange for the Board office to receive a license verification from *each* jurisdiction listed above, sent *directly* from the jurisdiction to the Board office.

12. Have you ever held any other healthcare license? Yes ☐ No ☐ If yes, enter the following information about *each* license:

TYPE OF LICENSE	JURISDICTION	HAS THIS LICENSE BEEN DISCIPLINED?	IF DISCIPLINED, EXPLAIN:
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	

13. Enter the following information about the locations and dates of your practice. *Include military service.*

EMPLOYER/ PRACTICE NAME	ADDRESS WHERE PRACTICED	NATURE OF PRACTICE	EMPLOYMENT DATES

If you are applying by *Reciprocity* and no jurisdiction where you are currently licensed has substantially similar requirements to those of Delaware, you must document at least five years of practice after licensure. For periods of employment, arrange for your employer(s) to send *Verification of Employment* forms directly to the Board office. For periods of self-employment, submit tax forms or business licenses for the periods.

14. List hospital staff affiliations and duration. Attach additional sheets if needed.

HOSPITAL NAME	<u>COMPLETE</u> ADDRESS	SERVICE DATES

## DISCLOSURES

15. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ If yes, submit a certified copy of your criminal history record.
16. Have you ever been *denied* a podiatric or other healthcare license by any jurisdiction? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Include the license type, jurisdiction, and the reason for each denial.
17. Have you been the recipient of any administrative penalties regarding your practice of podiatry in any jurisdictions – such as fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations – or have you been a party to a consent agreement containing conditions placed by a board on your professional conduct and practice, including any voluntary surrender of a license? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
18. Have you ever had a podiatric license revoked, suspended, limited, or placed on probation? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
19. Have you ever had a disciplinary action taken against you by a Podiatric Medical Society? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
20. Has a hospital ever changed your privileges as a result of a disciplinary action? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
21. Are any unresolved complaints pending against you? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
22. Are any charges pending against you, or are you currently under investigation for felony, misdemeanor, unprofessional conduct, professional misconduct, or malpractice? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
23. Have you ever been denied a narcotic license (controlled substance registration) or had such license modified, restricted, suspended, canceled, or revoked, or have you ever prescribed narcotic drugs unlawfully? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
24. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, the Drug Enforcement Agency of the Department of Justice, or any state's Narcotic Agency in this country or any other country? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
25. Have you ever:
- Engaged in the practice of podiatric medicine without a license? Yes ☐ No ☐
  - Employed or knowingly cooperated in fraud or material deception to acquire a podiatric license? Yes ☐ No ☐
  - Impersonated another person holding a podiatric license? Yes ☐ No ☐
  - Allowed another person to use your podiatric license? Yes ☐ No ☐
  - Aided or abetted anyone not licensed as a podiatrist to represent him or herself as a podiatrist? Yes ☐ No ☐

If yes to any one of the above, explain fully on a separate sheet of paper. Provide copies of all relevant documents.

26. Have you ever entered into a settlement, or had a verdict rendered against you, in a malpractice action?  
Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
27. Are you now, or within the last three years have you been, dependent upon the use of alcohol, stimulants, or habit-forming drugs or alcohol or been treated or disciplined for their use? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
28. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper.
29. Are you currently physically and mentally *capable* of practicing podiatric medicine and surgery according to generally accepted standards? Yes ☐ No ☐ If no, continue with the next question. If yes, skip to the DUTY TO REPORT section.
30. Do you agree to submit to an examination to determine such capability as the Board may deem necessary?  
Yes ☐ No ☐

### DUTY TO REPORT

31. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
- medically incompetent
  - mentally or physically unable to engage safely in the practice of medicine
  - excessively using or abusing drugs including alcohol.

I certify that I have read and understand the provisions of [24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A](#) and that I understand my *duty to report*. Yes ☐ No ☐

32. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes ☐ No ☐

33. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** duty to **self report** when your podiatrist license in another jurisdiction has been subject to discipline or has been surrendered, suspended or revoked.

I certify that I have read and understand [24 Del. C. §514 \(a\)\(8\)](#) and that I understand my *duty to self report*.  
Yes ☐ No ☐

**To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:**

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

**Applications that are not complete within six months of filing may be considered abandoned and discarded.**

**Please note: When your application is complete, please allow 4-8 weeks to receive your license.**

# AFFIDAVIT

*This section to be completed in the presence of a notary public.*

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

The above applicant, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

Signature of Notary Public: \_\_\_\_\_

SEAL

My commission expires on \_\_\_\_\_

**APPLICATIONS THAT ARE INCOMPLETE, UNSIGNED, NOT NOTARIZED OR NOT ACCOMPANIED BY THE  
REQUIRED FEE WILL BE REJECTED.**



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**EMPLOYMENT VERIFICATION FORM**

Applicants for Delaware podiatric licensure by Reciprocity must arrange for the Board to receive documentation of five years of practice after licensure if the jurisdiction where they are licensed does not have licensure requirements that are substantially similar to those of Delaware (Section 4.4 of the Board's Rules and Regulations). The purpose of this form is to document periods of podiatric employment in such jurisdictions.

**APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION**

Complete and sign this release. Send a copy to each employer.

Applicant Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I authorize release of information about my podiatric employment to the Delaware Board of Podiatry.

**APPLICANT SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Complete and sign in the presence of notary. Only forms mailed directly from the employer will be accepted. Forms returned by the applicant will not be accepted. Faxed forms will not be accepted.

1. Name of Practice Where Applicant Employed: \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

3. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

4. Name of Person Providing Verification: \_\_\_\_\_

5. Title: \_\_\_\_\_

6. The employee named above worked at this practice from \_\_\_\_\_ to \_\_\_\_\_  
Start Date End Date

7. This employment was in the State of \_\_\_\_\_.

**SIGNATURE OF EMPLOYER REPRESENTATIVE:** \_\_\_\_\_ Date: \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Commission expires: \_\_\_\_\_

SEAL

**Mail completed, signed, notarized form directly to the Board of Podiatry at address above.**